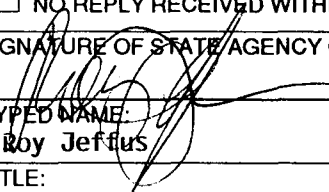
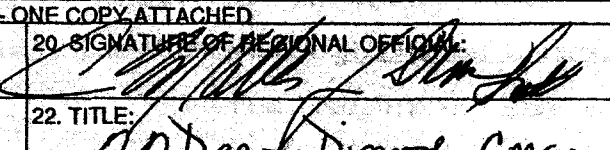


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <div style="text-align: center;">0 4 — 0 1 6</div>	2. STATE: <div style="text-align: center;">AR</div>
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">07-01-04</div>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <div style="text-align: center;">42 CFR Part 447, Sub Part C</div>		7. FEDERAL BUDGET IMPACT: a. FFY 2005 \$ 1,900,254 b. FFY 2006 \$ 1,975,693	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Appendix I Page 2-2a, 2-2aa		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, Appendix I Page 2-2a, 2-2aa	
10. SUBJECT OF AMENDMENT: The required minimum occupancy was to have increased from 75% to 81% when calculating rates for State Fiscal Year (SFY) 2005 and 81% to 85% for SFY 2006. Instead, the required minimum occupancy will increase to 77% for SFY 2005 and will increase 1% for the following three years.			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Division of Medical Services P.O. Box 1437 Little Rock, AR 72203-1437 Attn: Carolyn Patrick Slot S295	
13. TYPED NAME: Roy Jeffus		17. DATE RECEIVED: <div style="text-align: center;">AUG 26 2004</div>	
14. TITLE: Director		18. DATE APPROVED: <div style="text-align: center;">SEP 14 2004</div>	
15. DATE SUBMITTED: August 25, 2004		FOR REGIONAL OFFICE USE ONLY	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: center;">JUL - 1 2004</div>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Carmen Keller		22. TITLE: Deputy Director, CMSO	
23. REMARKS:			

component of the rate will rebase annually for the period July 1st to June 30th. An inflation index will be applied to the provider's direct care per diem cost to inflate cost from the cost reporting period to the rate period.

B. Indirect, Administrative, and Operating

For initial rate setting, the per diem payment for this component will be set at 110% of the median indirect, administrative, and operating per diem cost adjusted for inflation using the inflation index (see Section A. 5.) and paid as a class rate to all facilities. This per diem payment will be rebased at least once every three years. For rate periods in which the indirect, administrative, and operating cost component is not rebased, the existing indirect, administrative and operating per diem will be inflated forward into the next rate period using the inflation index. For each year in which costs are rebased, the per diem will be calculated in the same manner as used in the initial rate setting process.

C. Fair Market Rental

A fair rental system will be used to reimburse property costs. The fair rental system reduces the wide disparity in the cost of property payments for basically the same service therefore making this payment fairer to all participants in the program. The fair market rental system will be used in lieu of actual cost and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The fair rental payment for facilities that are leased from a related party will be calculated from the costs associated with the related party in conformity with related party regulations.

The payment for provider property cost will be calculated annually by adding the return on equity, facility rental factor, and the cost of ownership, and dividing the sum of these three components by the greater of the actual resident days or resident days calculated at the following occupancy levels. In addition to the annual rate calculation, an occupancy adjustment may be made each July 1st to the interim rate.

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STATE <u>Arkansas</u>	
DATE REC'D <u>AUG 26 2004</u>	
DATE APP'D <u>SEP 14 2004</u>	
DATE EFF _____	
HCFA 179 _____	

	Cost Report Period	Rate Period	% Occupancy
Year 1	SFY 2001	SFY 2002	75%
Year 2	SFY 2002	SFY 2003	75%
Year 3	SFY 2003	SFY 2004	75%
Year 4	SFY 2004	SFY 2005	77%
Year 5	SFY 2005	SFY 2006	78%

Year 6	SFY 2006	SFY 2007	79%
Year 7	SFY 2007	SFY 2008 and beyond	80%

Resident days at the minimum occupancy level are calculated as: *Total Licensed Beds x Number of Days in the Period x Minimum Occupancy Percentage.*

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DATE EFF <u> </u>	
HCFA 179 <u> </u>	